# Texas Department of Insurance

***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov


## *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

### *GENERAL INFORMATION*

**Requestor Name and Address**

VIA CHRISTI REGIONAL MEDICAL CENTER
4315 W LOVERS LANE
DALLAS, TX 75209

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 54

**MFDR Tracking Number**
M4-13-1310-01

**MFDR Date Received**
JANUARY 24, 2013

### *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Via Christi Regional Medical Center would show that the total charges were $494,996.54 as shown in two (2) separate billings for the periods of January 24, 2012 to February 24, 2102 ($458,317.99) and the period of time from February 25, 2012 to March 6, 2012 ($36,678.55). The provider will confirm that Texas Mutual did make a partial payment on these bills totaling $165,920.76 broken down as follows: January 4, 2012 to February 24, 2012 $152,467.34 and February 25, 2012 to March 6, 2012 $13,453.42. This leaves a remaining balance of $329,075.78 although this amount is reasonable and necessary and customary for the care received by [injured worker] at Via Christi Regional Medical Center, the provider is requesting payment of $180,576.82. This amount is fully supported by the Affidavits provided to the Medical Dispute Division."

**Amount in Dispute:** $180,576.82

### *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Texas Mutual paid $152,467.34 on the first bill, ie. 1/24/12 through 2/24/12 with billed amount $458,317.99. The amount paid on the second bill was derived by substracting $152,467.34 from $165,920.76, the calculated amount for the total of all billed charges and for the complete date range. The difference between $152,467.34 and $165,920.76 is $13,453.42, the amount Texas Mutual paid on the second bill. However, the requestor is dissatisfied with the total payment amount and seeks payment of an additional $180,576.82. The basis for this is the requestor's argument that "… the care was unusually extensive and costly… that [injured worker] treatment was fair and reasonable…" And finally, "… the provider's medical charges were fair and reasonable…" (Exhibit 6, requestor's DWC-60 packet.) … No further payment is due."

**Response Submitted by:** Texas Mutual Insurance Company

### *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 24, 2012 through March 06, 2012 | Inpatient Hospital Surgical Services | $180,576.82 | $0.00 |

### *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated April 06, 2012

- CAC-W1 – Workers Compensation State Fee Schedule Adjustment
- CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 217 – The value of this procedure is included in the value of another procedure performed on this date
- 468 – Reimbursement is based on the Medical Hospital Inpatient Prospective payment system methodology

Explanation of benefits dated April 20, 2012

- CAC-W1 – Workers Compensation State Fee Schedule Adjustment
- CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 217 – The value of this procedure is included in the value of another procedure performed on this date
- 468 – Reimbursement is based on the Medical Hospital Inpatient Prospective payment system methodology

**Issues**

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

**Findings**

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 143 percent; unless

   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

3. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is 927, and that the services were provided at Via Christi Hospitals. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $116,028.57. This amount

multiplied by 143% results in a MAR of $165,920.86.

4. The division concludes that the total allowable reimbursement for the services in dispute is $165,920.86. The respondent issued payment in the amount of $165,920.76. Based upon the documentation submitted, no additional reimbursement is recommended.

**Conclusion**

For the reasons stated above, the division finds that no additional reimbursement is due.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | 5/9/13 |
| Signature | Medical Fee Dispute Resolution Officer | Date |
| | | 5/9/13 |
| Signature | Healthcare Business Management Director | Date |

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-481**.